LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
QUARTERLY COUNTYWIDE CHILDREN'S QUALITY IMPROVEMENT COMMITTEE (QIC) MEETING

Type of Meeting	**Quarterly Countywide Children's QIC**	**Date**	**February 12, 2015**
Place	**600 S. Commonwealth Ave. Conference Room 113 Los Angeles, CA 90005**	**Start Time:**	**10 AM**
Chairperson	**Debra Mahoney**	**End Time:**	**12 PM**
Co-Chair	**Alyssa Bray**		
Members Present	Ashlei Sullivan, Audrey Fisher-Price, Beatriz Teroy, Carmen Russell, Carmen Vargas, Charity Wabuke, Claudia Felix, Darin Rorrer, Debbie Jih, Debra Cifuentes-Hernandez, Debra Mahoney, Diana Scott, Elizabeth Townsend, Emily Dual, Felicia Bolden, Frederick Martone, Hrug Ghazarian, Jim Adams, Kathleen Kim, Kathryn Stroupe, Kendra Valdez, Kimberly Green, Kristin Howard, Laura Villa, Lisa Harvey, Marcel Mendoza, Maria Bhattachan, Marisol Lara, Mark Rodriguez, Martin McDermott, Michael Boroff, Michael Miller, Michelle Ferrante, Mike Ford, Mike Olsen, Scott Tommey, Silvia Yan, Tatiana Van Beeck, Vandana Joshi, Yun Pak		

Agenda Item	**Discussion and Findings**	**Decisions, Recommendations, Actions, & Scheduled Tasks**	**Person Responsible**
Call to Order & Introductions	The meeting was called to order at 10 AM.	Introductions were made.	Debra Mahoney & Alyssa Bray
Review of Minutes	November 20, 2014 minutes were reviewed.	Minutes were approved	LAC DMH Providers

Agenda Item & Presenter	Discussion & Findings	Decisions, Recommendations, Actions, & Scheduled Tasks	Person Responsible
Quality Improvement (QI) **Cal MediConnect**	Cal MediConnect is a three year demonstration project between California (CA) Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). It is designed to integrate Medi-Cal and Medicare for those participating in both programs. These "dual eligibles" or "Medi-Medis" may enroll in a single managed care health plan to receive all of their covered benefits. Participation is voluntary.	Providers should explain the program to dual eligibles and request that they sign an authorization to exchange information between the mental health and health plans. DMH Client Treatment Plans should then be faxed to the health plan as soon as they are available. (See the attached handout.)	LAC DMH Providers serving the dual eligible population
Safety Intelligence (SI)	SI is the new online clinical event reporting system. The Office of the Medical Director (OMD) is compiling a list of Users identified by Providers on the User Role Spread Sheet which was distributed at the All Providers Meeting on October 29, 2014, and sent via email on 1/13/15 by the Countywide Children's Service Area (SA) Liaison.	Providers that have not already submitted the spread sheet should email it as soon as possible to: dcrain@dmh.lacounty.gov. (See the attached: Clarification on User Roles for Safety Intelligence)	LAC DMH Providers David Crain is the OMD staff compiling the list.
External Quality Review Organization (EQRO)	CA has contracted with a new EQRO, Behavioral Health Concepts, Inc. The LAC DMH site review will be held April 27-30, with a focus on SA 7 and 8. DMH will be working closely with SA District Chiefs and Liaisons during this process.		
QI Division Goals	The QI Division is in the process of completing the QI Evaluation Summary for Calendar Year (CY) 2014 and Work Plan Goals for CY 2015.	SA Liaisons will distribute these as soon as they are complete.	SA Liaisons
New Patients' Rights Posters	Countywide Children's Providers who attended the last QIC received one new poster for each provider number.	If you did not receive one new poster per provider number, contact your contract liaison. Those needing extra posters should send an email to: clewis@dmh.lacounty.gov and ask for a confirmation receipt.	Carol Lewis is the Patients' Rights contact for extra posters.

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Cultural Competency Committee (CCC) Updates	The annual CCC schedule was distributed at the QIC and is an attachment to this document. We also attached two other CCC documents: (1) The California Reducing Disparities Project (CRDP) Reports Recommendations Matrix focuses on factors affecting disparity among African American, Asian and Pacific Islander, Latino, LGBTQ, and Native American populations.	Providers are encouraged to assign designees to attend the various committee meetings to ensure staff is aware of the cultural competency requirements for all clients served.	LAC DMH Providers
	(2) Policy/Procedure 202.17: **Hearing Impaired Mental Health Access** describes the DMH policy/ procedure for providing equal access to services for consumers with hearing impairments, 24 hours a day, 7 days a week via the ACCESS Center. Sign language interpretation services are free of cost to consumers.	Providers should review the policy/procedure for those requesting sign language interpretation services.	LAC DMH Providers
SA Directories Vandana Joshi	Dr. Joshi identified three ways Providers can review their SA Directory information: http://dmh.lacounty.gov/wps/portal/dmh On the right-hand side of the page is a box under **Mental Health Programs/Services.** Enter the address, city or zip code for the provider site and press **GO**. http://psbqi.dmh.lacounty.gov/providerdirectory.htm The Network of Care: http://losangeles.networkofcare.org/mh/services/index.aspx	Providers should review their SA Directory information and email Debra Mahoney at dmahoney@dmh.lacounty.gov, with corrections. Official changes of address still require a Provider File Adjustment Request (PFAR).	LAC DMH Providers and Countywide Children's SA Liaison

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Quality Assurance (QA) **National Committee for Quality Assurance (NCQA)**	QA will be meeting with the Mihalik consulting group to discuss and evaluate the possibility of obtaining NCQA accreditation for LAC DMH. Many health plans require its providers to be NCQA accredited. DMH does not have plans to require contractors to be NCQA accredited.		LAC DMH
Medi-Cal Certification/Re-Certification Elizabeth Townsend	Elizabeth Townsend reviewed the requirements for Medi-Cal Certification/Re-Certification and asked that Providers carefully prepare for their site certification/ recertification in advance.	See the attached documents, which can also be found at: http://psbqi.dmh.lacounty.gov/QA_MediCal.htm	LAC DMH Providers
Certification Bulletin No. 15-01	The bulletin can be found at the above link and is an attachment to these minutes. It states that separate provider numbers are required for modes/service function codes when lockouts exist.	The Medi-Cal Certification Section will contact Providers when modes/service function codes need to be separated by two or more Provider Numbers.	Medi-Cal Certification Section
DSM 5 and ICD 10	DSM 5 implementation may not occur by October 1, 2015. The delay is related to 16 diagnoses that are up for discussion as to whether they will be "included." However, ICD-10 claiming activities will probably commence on schedule. The State is working out the details of the crosswalk.	More information and training will be provided in the future.	LAC DMH
QA Process Reports	All Countywide Children's Providers have submitted their QA Process Reports. The QA Division is reviewing them for content and will inform Providers if their documents need to be amended using the Corrective Action Plan for QA Report for LE Contractors form.		LAC DMH
Clinical Documentation Training	QA understands the need for more training. They are currently developing a targeted case management/ rehabilitation training. Check the Training & Workforce Development website for updates.	Providers enrolled in QA training should make sure to cancel their registration, if they are unable to attend, to make room for those on the waiting list.	LAC DMH Providers

Handouts	Cal MediConnect: QIC Presentation Clarification on User Roles for Safety Intelligence CCC Schedule CRDP Reports Recommendations Matrix Policy/Procedure 202.17 Overview and Instructions for New Certifications Provider Site Re-Certification Protocol Contract Provider Re-Certification Worksheet Medi-Cal Certification Bulletin No. 15-01		
Announcements	LAC Board of Supervisors has proposed a consolidation of DHS, DMH and DPH: Many stakeholder meetings are convening to discuss the pros and cons of a consolidated agency.		
Next Meeting	The next Countywide Children's QIC will be held on May 14, 2015 at 600 S. Commonwealth Ave., 2nd Floor Conference Room 113, Los Angeles, CA 90005		

Respectfully Submitted by Debra Mahoney

Clarification on User Roles for Safety Intelligence

Thank you for your diligence in completing the attached User Role Spreadsheet assigning user roles for the DMH Safety Intelligence Event Reporting System. The following is a clarification of user roles. If you have already submitted the User Role Spreadsheet, we will review the submission to determine if more information is needed.

The four roles are:

1. **Reporter**: This optional role can be assigned to any staff in your agency who you determine should report a clinical event in addition to the manager. You may have as many reporters as necessary based on your agencies' workflow, however every reporter must have an RSA token to access the SI system on the DMH internet. Event reports submitted by reporters will not be reviewed by DMH Clinical Risk Management unless the report is flagged as overdue for the agency's manager to review. Agency Managers will receive notification that a report in their area has been submitted and they will have a certain timeframe for review. Clinical Risk management will review the reports after the agency manager has completed their review. Reporters are not listed on your agency's User Role Spreadsheet. The identity of the reporter is not known to the system and can be kept anonymous unless the reporter completes the reporter information on the event report.

2. **Manager**: The manager, who most often is also the reporter, begins the managerial review section of event reports entered into the system by reporters within 3 business days and will have 30 calendar days from the date of the event to complete the report. There should be only one Manager per provider number in a service area. Managers must have an RSA token to access the SI system on the DMH internet website and be listed on the User Role Spreadsheet for the Legal Entity submitted to DMH. The manager will create a user name and password in the SI system in order to access the level of the system necessary to review submitted reports.

3. **Designee:** The Designee is assigned by the Manager to review and complete SI reports in the Manager's absence and should be at the same level as the manager or higher. Ideally, to maintain the integrity of the review process, there should only be one designee per manager. Designees must have an RSA token to access the SI system on the DMH internet website and be listed on the User Role Spreadsheet for the Legal Entity submitted to DMH. The designee will create a user name and password in the SI system in order to access the level of the system necessary to review submitted reports.

4. **Consultant**: The Consultant accesses submitted reports for review when requested by the manager or designee. This role could be assigned to a Medical Director, QI officer or others who review events for clinical and/ or quality issues. A consultant must have an RSA token to access the SI system on the DMH internet website and be listed on the User Role Spreadsheet for the Legal Entity submitted to DMH. The consultant will create a user name and password in the SI system to access the level of the system necessary to review submitted reports.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU

QUALITY IMPROVEMENT DIVISION

CULTURAL COMPETENCY UNIT

CALIFORNIA REDUCING DISPARITY PROJECT REPORTS

RECOMMENDATIONS MATRIX

January 2014

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU

QUALITY IMPROVEMENT DIVISION

CULTURAL COMPETENCY UNIT

CALIFORNIA REDUCING DISPARITY PROJECT REPORTS
RECOMMENDATIONS MATRIX

The California Reducing Disparities Project (CRDP), funded through the Prevention and Early Intervention (PEI) component of the MHSA, generated five population-specific reports or strategic plans. These CRDP reports stem from awareness of the increasing population growth in California of racial and ethnic, linguistic, and LGBTQ communities. Each of the five reports represents the collaborative work and community voices of the following underrepresented groups: African American, Asian Pacific Islander, Native American, Latino and LGBTQ. Each report supports community-defined practices, and delineates the concerns and recommendations of each population group with the goal of closing the disparities gap in the delivery of health care services in California.

Each CRDP report highlights culture-specific traits and health care needs, as well as needs that are similar to the other groups. The CRDP Recommendations Matrix, developed by the LACDMH Program Support Bureau, Cultural Competency Unit, represents a collaborative effort to carefully identify some of the general cultural recommendations endorsed by each group--as well as the culture-specific recommendations of each group—with the goal of providing a visual presentation of the recommendations to make them readily accessible and easily understood. The initial phase of developing the matrix consisted of identifying specific theme categories related to reducing health care disparities. The second phase involved selecting recommendations endorsed by the five groups, then organizing them—according to their respective population group--into the identified theme categories of the matrix. The final phase entailed identifying--and including in the last pages of the matrix—the specific themes and recommendations of each population group that exclusively target that group's health care needs. As such, the information in the CRDP Recommendations Matrix provides a basis upon which new strategies, approaches, and interventions can be identified and supported in order to achieve a higher level of cultural competency and eliminate current disparities in service delivery to the five identified underserved populations.

It warrants mentioning that the recommendations presented in the CRDP Recommendations Matrix are not intended to be all inclusive. Rather, the matrix developers carefully selected what appeared to be the most salient recommendations endorsed by each of the five population groups. Additionally, the matrix is not intended to be interpreted as presenting recommendations that are of concern only to the group(s) that included them in their CRDP report. In other words, although several recommendations may have been cited only in some CRDP reports, they could also be of crucial concern to all five groups.

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The recommendations from the five CRDP Reports have been collectively organized under the following twelve themes:

- System Capacity of Communities
- Services Accessibility in Communities
- General Cultural Recommendations
- Workforce Development
- Outreach and Engagement in Communities
- Service Delivery in Communities
- Prevention and Early Intervention
- Funding/MHSA Funding
- Outcome Measures, Research and Data Collection
- Leadership Development
- Policies & Procedures (P&Ps) to be Developed and Implemented
- Specific Cultural Recommendations

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

No	Recommendation Themes	Theme Representation in CRDP Reports by Group				
		AA	NA	API	Latino	LGBTQ
I	**System Capacity of Communities**					
I.1	Provide technical assistance to enhance capacity for linkage to cultural competent services	p.205, 139, 110, 258	p.29	p.81	p.ix	p.177
I.2	Promote grassroot community partnerships	p.253, 251			p.ix	
I.3	Support culturally competent collaboration with Stakeholders	Appendix 9, p.212		p.81	p.ix	p.61
I.4	Partner with academic institutions	p.8, Strategy #4		p.80	p.ix	p.177
I.5	Partner with faith-based organizations	p. 174		p.59	p.42	p.175
I.6	Partner with community-based organizations	p. 3,9,179		p.59	p.42	p.178
I.7	Partner with ethnic/tribal/indigenous cultural communities and/or subpopulations		p.32		p.44	p.178
I.8	Develop credibility/ trust within the community	p. 256		p.61	p.40	p.175
I.9	Work together to implement promising practices	p. 235	p.14	p.66	p.42	
I.10	Join efforts in decision-making process and policy making	p. 241		p.xiv	p.44	p.172
II	**Service Accessibility in Communities**					
II.1	Provide services in the preferred language of consumers			p.84	p.43	p.179
II.2	Provide convenient service location, hours of operation and extended time of sessions	p. 175, 176	p.6	p.xiv	p.42	p.159
II.3	Include ancillary/social services as part of mental health service delivery	p. 175, 176	p.11	p.xiv	p.42	
II.4	Provide transportation for mental health services	p. 178, 256	p.11	p.52	p.29	
II.5	Provide streamline access for linkage and contract agencies/organizations	p. 178	p.11	p.47	p.42	p.177
II.6	Engage in co-location of services and resources	p. 240		p.82	p.38	
II.7	Establish infrastructure for leverage/sharing of resources	p. 289		p.82	p.42	
II.8	Provide resources to bilingual staff			p.27	p.37	p.179
II.9	Invest in language translation and interpretation resources			p.84	p.43	p.179
II.10	Establish a welcoming/safe environment for consumers and employees	p. 105, 173	p.16	p.51	p.43	p.179
II.11	Translated forms/docs to contain respectful language for all cultural populations				p.43	p.179

*CRDP Report states this recommendation as a converse statement.

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III	**General Cultural Recommendations**					
III.1	Modify service eligibility requirements for cultural manifestation of symptoms and medical necessity		p.8	p.79		
III.2	Respect within-group diversity	p. 12,18,23,32	p.9	p.81	p.40	p.11
III.3	Understand and respect cultural/historical factors/experiences of historical trauma	p.253	p.7	p.xv	p.27	p.32
III.4	Promote sensitivity to issues specific to cultural groups traditional beliefs in service delivery and program design	p.256, 253	p.7	p.xvi	p.40	p.179
III.5	Beware that DSM nomenclature excludes cultural groups' views of health and wellness	p.65	p.7	p.79	p.24	p.25
III.6	Take cultural differences into consideration prior to establishing a DSM diagnosis	p.65	p.7	p.79	p.24	p.125
III.7	Address acculturation issues (stressors, search for personal identity, etc.)	p.33		p.ix	p.9	p.83
III.8	Integrate spiritual practices, cultural customs and traditions for wellness	p.251	p.13	p.xv	p.40	
III.9	Work with strengths of each cultural group rather than focusing on weaknesses	p.8	p.18	p.xvi	p.12	p.123
III.10	Aim at reducing stigma	p.1. 253, 254	p.11	p.xvi	p.6	p.175
III.11	Support LGBTQ research	p. 148,253		p.66		p.173
III.12	Continue advocating for implementation of CRDP recommendations	p.253	p.28	p.60	p.ix	p.172
IV	**Workforce Development**					
IV.1	Promote effectiveness in working with language interpreters			p.61	p.27	
IV.2	Employ, train, support, and retain cultural and linguistic competent staff	p.257		p.79	p.43	p.177
IV.3	Provide mentorship for future workforce			p.80	p.32	p.177
IV.4	Provide on-going training and supervision	p.257		p.51	p.43	p.165
IV.5	Promote mental health careers to youth and their parents			p.80	p.43	
IV.6	Academic institutions should define clear certification standards and career paths for the mental health workforce				p.43	p.94
IV.7	Expand loan forgiveness programs				p.43	
IV.8	Support LGBTQ mental health career path development				p.43	p.94
IV.9	Develop and implement ongoing cultural competency training standards defining cultural competent services and interventions	p.257				
IV.10	Offer on-going cultural competency training and technical assistance for service providers	p.257	p.33	p.80	p.43	p.177

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IV.11	Offer peer-to-peer trainings	p. 183	p.21	p.xx	p.40	
IV.12	Include LGBTQ in diversity trainings by subpopulation (specific issues/needs of L,G,B,T,Q)			p.84	p.69	p.19
V	**Outreach and Engagement (O&E) in Communities**					
V.1	Outreach, educate and raise awareness of LGBTQ issues				p.42	
V.2	Include mental health education in school curriculum	p.178			p.41	p.174
V.3	Ensure culturally relevant O&E and educational campaigns		p.19	p.79	p.40	p.175
V.4	Ensure linguistic appropriateness of O&E activities			p.58	p.40	
V.5	Educate the community on mental health issues and services in order to remove cultural barriers and stigma to seeking and receiving MHS		p.11	p.51	p.41	p.175
V.6	Promote peer-to-peer support and family-to-family outreach and education	183	p.8	p.58	p.40	p.12,14, 105
V.7	Use of innovative venues (culture specific) for O&E		p.9	p.x	p.43	p.175
V.8	Tailor O&E interventions specifically for age groups	p.99,100,210		p.vii	p.41	p.176
V.9	Utilize computer technology	p.192		p.xx	p.36	p.12
V.10	Conduct O&E through faith-based organizations and schools	p.232		p.56	p.42	p.175
V.11	Promote reduction of homophobia and stigmatization of LGBTQ individuals				p.42	p.175
V.12	Increase awareness of mental health issues			p.78	p.41	p.175
V.13	Accurately portray mental health problems and provide information on mental health services			p.27	p.41	
V.14	Outreach to youth across a variety of media outlets			p.53	p.42	p.108
VI	**Service Delivery in Communities**					
VI.1	Integrate mental health, physical health and substance abuse in service delivery	p.250, 251	p.16	p.78	p.40	
VI.2	Address risk behaviors (including gangs, drug use, teen pregnancy, and domestic violence) in clinical assessment and intervention		p.10		p.30	p.179
VI.3	Include family psychoeducational approach to wellness and health		p.12	p.xv	p.40	p.92
VI.4	Provide parenting classes		p.19	p.66	p.34	p.92

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VI.5	Support Community-Defined Practices and other community models as alternative/complement to mental health services		p.15	p.81	p.30	p.181
VI.6	Develop cultural competency programs for unmet/emerging needs		p.15	p.81	p.40	p.180
VI.7	Integrate family/community traditional and cultural practices in service delivery and evaluation		p.15	p.57	p.40	p.177
VI.8	Suicide prevention programs need to identify and assess risks specific to LGBTQ populations across cultural groups				p.25	p.176
VI.9	Implement Evidence-Based Practices (EBPs) interventions for bullying					p.174
VI.10	Advocate for consumer needs		p.18	p.59	p.32	p.173
VI.11	Address housing issues	p.253	p.11		p.29	p.39
VII	**Prevention and Early Intervention (PEI)**					
VII.1	Develop a PEI funding structure	p.249, 253	p.26	p.79	p.44	p.177
VII.2	Invest in early detection/intervention with youth	p.250	p.26	p.67	p.34	p.179
VII.3	Implement to reduce risk of incarceration, drug use and mental illness in youth	p.253			p.34	
VII.4	Support PEI initiatives/ interventions	p. 249, 214	p.26		p.40	
VII.5	Support staff's training on PEI strategies	p.254		p.79	p.43	
VII.6	Focus PEI attention on suicide prevention	p.254	p.19	p.66	p.25	p.121
VIII	**Funding/MHSA Funding**					
VIII.1	Align funding with population demographics, including Federal Poverty Levels			p.16	p.44	p.173
VIII.2	Focus funding on direct services		p.29	p.30	p.44	
VIII.3	Make funding available for all service operational needs (e.g. interpretation, evaluation)		p.29	p.ix	p.44	
VIII.4	Remove funding barriers for community-based organizations and community programs		p.29	p.59	p.44	p.178
VIII.5	Incorporate CRDP recommendations in funding		p.30		p.44	p.172
VIII.6	Fund target population resource guides		p.43			p.180
VIII.7	Monitor and show agency accountability for target populations mental health services		p.30	p.54,56,60	p.39	p.178

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IX	**Outcome Measures, Research, and Data Collection**					
IX.1	Support validation of Community-Defined Practices		p.33	p.xiv	p.30	p.181
IX.2	Focus technical assistance on invoicing, data collection and reporting, and program evaluation		p.29	p.54		
IX.3	Provide technical assistance to develop, refine and validate promising practices		p.30	p.81	p.16	p.181
IX.4	Conduct reviews of Evidence-Based Practices (EBPs), Community-Defined and Promising Practices		p.31	p.81	p.39	
IX.5	Invest in research and replication of Community-Defined programs and EBPs		p.15	p.81	p.44	p.181
IX.6	Work with community for EBP implementation and evaluation		p.31	p.xiv		
IX.7	Support development of community-specific outcome measures		p.15	p.81	p.39	p.181
IX.8	Develop cultural competency outcome measures to measure program effectiveness		p.14	p.81	p.39	p.181
IX.9	Consider standardization of outcome measurements		p.31		p.39	p.172
IX.10	Engage in community participatory research		p.28	p.81	p.39	p.181
IX.11	Address research gap for subpopulations (e.g. multi-racial, ethnic and LGBTQ identity)		p.9	p.85		p.173
IX.12	Support culture-specific program evaluation		p.12	p.81	p.39	p.181
IX.13	Evaluate increase in access to services, retention rates and reduce drop outs			p.60	p.39	
IX.14	Use of standardized questions to evaluate projects		p.31		p.39	
IX.15	Evaluate projects/programs using a "bottom up" orientation		p.15	p.37	p.43	
IX.16	Use community-driven evaluations to identify issues and solutions		p.15	p.37	p.39	
IX.17	Require accountability for funding allocation and service delivery from funded agencies		p.30	p.37	p.39	p.173
IX.18	Work with consultants who are experienced with specific cultural groups		p.31		p.39	p.173
IX.19	Drill down data collection and reporting for data disaggregation		p.29	p.x	p.24	p.172
IX.20	Use of quantitative and qualitative data collection and outcomes		p.31	p.x	p.39	
IX.21	Avoid U.S. Census data due to misclassification and undercount		p.29	*p.19	*p.44	p.105
IX.22	To measure providers' follow-up with CRDP Recommendations		p.30	p.80	p.44	p.172
IX.23	To measure effectiveness of mental health interventions				p.39	p.181

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		AA	NA	API	Latino	LGBTQ
X	**Promote Leadership Development**					
X.1	Gather leadership support and advocacy		p.18	p.81	p.40	p.173
X.2	Leadership should be representative of the community composition and include consumers, and family members (parents)		p.21		p.40	
X.3	Leadership to advocate for community needs		p.18	p.82	p.40	p.173
X.4	Leadership to facilitate the development of partnerships for service providers		p.25	p.81	p.44	
X.5	Leadership to ensure inclusion of traditional/culturally relevant practices in MHS		p.18	p.57	p.42	p.172
X.6	Leadership to advocate for and disseminate CRDP strategies and recommendations		p.28	p.80	p.44	p.172
X.7	Leadership to work collaborately with advisory councils/boards		p.28	p.78	p.40	p.172
X.8	Leadership (including politicians) to advocate for LGBTQ needs					p.173
X.9	Develop leadership training guidelines			p.81	p.43	
XI	**Recommendations for Policies & Procedures (P&Ps) to be Developed and Implemented**					
XI.1	Develop P&Ps that reflect community needs and cultural values			p.51	p.39	p.173
XI.2	Focus P&Ps on effective mental health services and outcomes			p.81	p.39	p.172
XI.3	Implement P&Ps that are consistent with the Fair Education Act				p.37	p.174
XI.4	Funded organizations to adopt anti-discrimination P&Ps for LGBTQ					p.174
XI.5	Develop health care P&Ps that are affirming and anti-discrimination for LGBTQ					p.179
XI.6	Generate FMLA (Family Medical Leave Act) P&P for LGBTQ					p.173
XI.7	Generate LGBTQ Anti-bullying P&Ps in schools (Seth's Law)					p.174
XI.8	Implement P&Ps that support linguistic appropriate care				p.43	
XII	**Specific Cultural Recommendations**					
XII.1	Domestic violence programs to address gender, sexual orientation and recognize LGBTQ domestic partnerships					p.173
XII.2	Support LGBTQ affirming activities at schools including trainings for parents of LGBTQ youth					p.111
XII.3	Implement a safe working environment for LGBTQ employees					p.179
XII.4	Ensure hired LGBTQ trainers have endorsement from LGBTQ communities					p.180

*CRDP Report states this recommendation as a converse statement.

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

No	Recommendation Themes	Theme Representation in CRDP Reports by Group				
		AA	NA	API	Latino	LGBTQ
XII.5	Provide training for school staff on LGBTQ sensitivity and bullying intervention					p.174
XII.6	Support capacity increase for LGBTQ agencies					p.178
XII.7	Gather specific demographical info across lifespan					p.172
XII.8	Include LGBTQ partners in domestic violence program statistics					p.173
XII.9	Expand Culturally and Linguistic Appropriate Services (CLAS) guidelines to include LGBTQ					p.179
XII.10	Air culture-specific products related to mental health (e.g. pláticas and fotonovelas)				p.43	
XII.11	Produce recordings of successful recovery of families				p.40	
XII.12	Work with ethnic media providers				p.42	
XII.13	Expand the Promotores de Salud Model				p.37	
XII.14	Offer conjoint cultural competency training for primary health care and mental health providers				p.42	
XII.15	Make CC training mandatory in college degree curriculum					
XII.16	Evaluate if integration leads to disparity reduction					
XII.17	Fund grants instead of Requests for Proposals		p.29			
XII.18	Funded projects to be managed at the State level		p.30			
XII.19	Hold quarterly meetings with project grantees and contractors		p.30			
XII.20	Only report input and outcomes of tribal ceremonies		p.31			
XII.21	**5 Strategic Action Categories That Specifically Target the African American Population (p.42-51)**					
	The CRDP African American Population Report calls for recommendations that are **SMART**: • **Strategic** (specifically targets African Americans) • **Measurable** (allows for cultural vetting of programs and services) • **Achievable** (monitored against real indicators of African American mental health) • **Required** (will address both necessary and sufficient conditions desired by African-American communities) • **Timely** (allows for concrete and guided action now)	p.250				
XII.21.1	The State should financially support African American Culture Centers which should become a hub for several recommendations that would help stabilize the black family unit (refer to #XII.21.2 - XII.21.8): • Culture Centers should utilize a holistic, cultural-based community level approach to mental health	p.253				
XII.21.2	Immediately implement culturally focused short term population-based crises care	p.250				

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County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

No	Recommendation Themes	Theme Representation in CRDP Reports by Group				
		AA	NA	API	Latino	LGBTQ
XII.21.3	Shift the emphasis of service delivery to Black populations away from diagnosis and prescriptions to screening, accurate assessment and identification of immediate needs	p.250				
XII.21.4	The State should fund and organize culturally congruent mobile intervention teams statewide at the county level, utilizing an interdisciplinary team of African American clinical psychologists, clinical social workers, and marriage and family therapists	p.251				
XII.21.5	The State should provide financial resources directly to Black led community-based organizations and continue providing meaningful programs, interventions, activities and holistic (i.e., wrap-around) services • Significantly fund, support, and replicate comprehensive family, community resources and wellness centers	p.251				
XII.21.6	The State should fund a statewide network of community healers and indigenous/traditional healers, which is critical to integrated care across service domains of behavioral health, mental health, substance abuse, and public health • Test and evaluate the efficiency of alternative mental health integration across domains	p.251				
XII.21.7	Establish prisoner re-entry “Places of Compassion” by working with the Criminal Justice System, local police departments, district attorneys, and faith/community-based organizations to develop alternative sentencing and housing options for the mentally ill entangled in the system and returning home under the re-alignment program (California AB 109) • Each county re-entry plan should be vetted by the community to prevent recidivism and further perpetuate the escalating crises • Significantly fund existing grassroots PEI programs in the Black community working with the formerly incarcerated and preventing recidivism	p.253				
XII.21.8	Establish a Network of Community Healers & Indigenous/Traditional Healers in order to allow the mental health system to become community-based, going to the people for assertive outreach, and fostering the natural support system of cultural healings that foster relationships that are naturally in the community, and respected by the community • Mandates must be established in the RFP contracting process; mental health training must be provided for professionals as well as community healers; and, materials must be created that involve interdisciplinary and trans-disciplinary approaches • Create and provide professional development opportunities for non-licensed workers (local community persons, lay-ministers, para-professionals, etc.) to obtain enhanced culturally-grounded mental health training in order to increase the number of service providers capable of providing culturally congruent services to African American clients	p. 253				

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County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.22	**Community-County Partnerships**					
XII.22.1	In every county, the Mental Health Services Oversight and Accountability Commission (MHSOAC) should establish culturally congruent community commissions that will report directly to the MHSOAC • Accountability of MHSA funds should be strictly enforced and mandated compliance should be governed by the people served • MHSA funds should be utilized to establish community governance to collaborate with the MHAC in providing culturally congruent community-based participatory research and programming with social service agencies in establishing evidence of the effectiveness of programs funded • Mandated Countywide African American Health Oversight Commissions (and other culturally congruent community commissions) will ensure that African American issues related to total health and well being are appropriately addressed using culturally appropriate approaches • Each commission should be composed of local county residents from a broad representation of people of African ancestry, including clients, family members, consumers, and other interested/invested community-based residents • Annual benchmarks and status reports should be generated for county level accountability of appropriate services rendered and the wellness status of residents	p.252				
XII.22.2	Culturally Congruent Community Evaluation Programs should be developed to assist the MHSOAC with its State mandated responsibility of monitoring and evaluating MHSA fund usage and provide funds for community-based organizations to conduct community participatory evaluation of programs providing services to people of African heritage • Program success outcomes should not be limited to “evidence-based programs” but should be given equal weight with community-defined practices • We recommend that culturally congruent evaluation modalities and measures used in this CRDP project be adapted and tested in recommended tailored PEI programs funded by the MHSA	p.252				

*CRDP Report states this recommendation as a converse statement.

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.22.3	Provide ongoing culturally congruent and directed training for first responders such as Faith Community (Clergy) and Law Enforcement (Officers) • Establish a statewide task force that includes "indigenous healers and community leaders" from every region within the State of California • Develop an RFP and contract to determine and develop the curriculum which should include: an overhaul of language used to address mental issues, individual regional approaches tailored to the community, a multilevel approach to respect diverse faith community practices, and approaches that will address stigma • Provide resources that can be used by the clergy and law enforcement to share with the community, and include an evaluation component • For law enforcement, training is needed for immediate assessment so that the person is not treated like a criminal when the person might in fact be sick, hard of hearing, deaf or legally blind • An "officer hotline" needs to be established for immediate assistance of a mental health professional to assist with assessment • Law enforcement must be trained on how to deal with "micro aggression" in the Black community • In the police academy, specific training MUST be offered on mental health on the same level as "hostage negotiation" when dealing with Black men	p.254				
XII.22.4	Develop opportunities for local health departments to attain enhanced awareness of Community Defined Evidence-Based Prevention and Early Intervention Programs (i.e., homegrown)	p.257				
XII.22.5	Address the need for more appropriate data collection on the Black population by mandating culturally congruent methods that document individual and community (ecological approach) positive actions for what is working well toward personal improvement, progress toward independence, and becoming a contributor • Progress reports and data outcome reports must be provided on a regular bases	p.257				

*CRDP Report states this recommendation as a converse statement.

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.23	**State Specialized African American Program Prototypes**					
XII.23.1	Immediately change the provision of services to Blacks by first conducting mass population-based screenings and trauma-based assessments for crisis level interventions conducted by trained African American providers • Promote and use the expertise of African American mental health service providers (see California African American Mental Health Providers Directory) as consultants for integrated health services for "whole persons" care, with special emphasis on young children, youth, older adults, the blind/deaf, and LGBTQI • Adopt a culture based approach for all service delivery, especially PEI	p.250				
XII.23.2	The State should Fund Existing Culturally Congruent Integrated Programs	p.251				
XII.23.3	Create a unique category of early intervention practice services that could potentially be a part of the African American Culturally Sensitive Services Program (AACSSP) • Define African American Culturally Sensitive Services that are unique and wanted by the population (see P. 256–257 for complete list & details) • The African American Culturally Sensitive Services Program (AACSSP) will give preference to the mentally challenged with limited access to transportation and services	p.255				
XII.23.4	Develop funding opportunities for Community Defined Evidence-Based Prevention and Early Intervention Programs (i.e., homegrown) to provide mental health services to African American clients	p.257				
XII.23.5	Utilize the recommended community practices and organizations associated with this CRDP African American Population Report to conduct research to test their efficacy for sustainability and expansion (see Table 54)	p.257				
XII.24	**Partner Alliances with the State on Accountability Mechanisms**					
XII.24.1	The MHSOAC should immediately develop and implement a due diligence process of "cultural vetting" (examination and evaluation) to determine the utility and effectiveness of programs and services in working with people of African heritage	p.251				

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County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.24.2	Establish culturally congruent community commissions that will report directly to the MHSOAC • Mandated compliance should be governed by the people served • MHSA funds should be utilized to establish community governance to collaborate with the MHSOAC in providing culturally congruent community-based participatory research and programming with social service agencies in establishing evidence of the effectiveness of programs funded • Annual benchmarks and status reports should be generated for county level accountability of appropriate services rendered and the wellness status of residents	p.252				
XII.24.3	Fund culturally congruent evaluation programs to assist the MHSOAC with its state mandated responsibility of monitoring and evaluating MHSA fund usage • Provide funds for community-based organizations to conduct community participatory evaluation of programs providing services to people of African heritage • Program success outcomes should not be limited to “evidence-based programs” but should be given equal weight with community-defined practices • Program outcome measures in the Black population should be based on the client desired practices as measured by quality of service delivery, wellness state and satisfactory client progress toward independence and self-sufficiency	p.252				
XII.24.4	Appoint an implementation workgroup for the recommended community-defined practices of all CRDP Population Reports • Respect and work with all diverse communities, especially the American Indians, Asian/ Pacific Islanders, LGBTQ, Latinos, and the African Americans who make up the majority of the citizens of California	p.253				
XII.24.5	All licensed mental health service providers must be certified by the Association of Black Psychologists in order to improve the skills of service providers to better provide culturally competent services to diverse African Americans	p.257				
XII.24.6	All mental health service providers should be provided cultural competency training in African American cultural orientation by African American trainers and providers in order to improve the delivery of services to African American clients	p.257				

*CRDP Report states this recommendation as a converse statement.

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.25	**Statewide Culturally Congruent Education**					
XII.25.1	Provide alternate education programs designed to educate, restore and revitalize the Black family unit and population (i.e., create "Community Healing Circles") • Provide extensive education programs for people of African heritage to learn about mental health to eliminate the stigma associated with mental illness (i.e., the NAMI family training model and Peer to Peer Program) • Launch public education campaigns on the nature of mental illness so family, friends and community members can recognize early warning signs and know how to take action and how to access resources to prevent a major episode • Utilize the Black media to promote a public education campaign designed like the national heart attack or stroke campaign	p.253				
XII.25.2	Conduct therapeutic training sessions on racism as of means of educating mental health practitioners and increasing sensitivity to the historical and contemporary mistreatment of people of African ancestry • Use the resources located in the family system and community; train clergy and lay persons in African American communities; and, educate parents about school-based interventions as a means of reducing Black teen suicide, and to also measure effectiveness over multiple domains of living and well being	p.254				
XII.25.3	All mental health service providers should be provided cultural competency training in African American cultural orientation by African American trainers and providers in order to improve the service delivery to African American clients	p.257				
XII.25.4	Create and provide opportunities for adoption and inclusion of culturally competent curricula developed by African Americans based on Community-Defined Evidence in a way that better serves diverse African Americans	p.257				
XII.25.5	Develop social marketing plans and outreach with Black media to expand and enhance understanding of Black culture with an emphasis on positive imagery for improved mental health and destroying erroneous ideologies about the population	p.257				

*CRDP Report states this recommendation as a converse statement.

County of Los Angeles Department of Mental Health
Program Support Bureau
Quality Improvement Division
Cultural Competency Unit
California Reducing Disparities Project (CRDP) Recommendations Matrix

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XII.25.6	The State should Fund the creation of Tailored PEI Outreach Materials on the nature of mental health and well-being for social marketing and education on the community level • PEI Outreach Materials should be able to be implemented by traditional mental health providers and non-traditional agencies (i.e., community-based organizations, churches, barber shops, beauty salons, professional athletes, entertainment industry, food industry, etc.) • Develop social marketing/networking plans and outreach based on the Internet and social media to expand and enhance understanding of mental health for African Americans	p.258				

*CRDP Report states this recommendation as a converse statement.